

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049221

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318 1003 12348

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN **ST LOUIS**

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** COUNTY

c. CITY OR TOWN **ST .LOUIS**

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION **6170 WATERMAN**

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)
6170 WATERMAN

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First **MARGARET** Middle **W** Last **BALDWIN**

4. DATE OF DEATH
Month **DEC** Day **12** Year **1963**

5. SEX
FEMALE

6. COLOR OR RACE
WHITE

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
9-10-1885

9. AGE (last birthday)
78

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY
At home

11. BIRTHPLACE (City and state or country)
St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Michael Ford

13b. MOTHER'S MAIDEN NAME

Margaret Welby

14. NAME OF HUSBAND OR WIFE

Harry E. Baldwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
none

17. INFORMANT
Harry E. Baldwin 6170 Waterman Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic Brain Syndrome

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cerebral arteriosclerosis

DUE TO (c)

334x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Diabetes Mellitus

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT, SUICIDE, HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **4-28-61** to **12-12-63** and last saw her alive on **11-14-63**
Death occurred at **2:00 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

950 FRANCIS PLACE

22c. DATE SIGNED

12-13-63

23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

23b. DATE
DEC 16 63

23c. NAME OF CEMETERY OR CREMATORY
CALVARY

23d. LOCATION (City, town, or county)
ST LOUIS MO

(State)

24. FUNERAL DIRECTOR

ADDRESS

E.J. SCHNUR 3125 LAFAYETTE

25. DATE RECD. BY LOCAL REG.

DEC 13 1963

26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

DR J. G. JANNEY
950 FRANCIS. PK
PA 66513 FRI 2-5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton R. Remelino

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.